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RURAL POOR AND RURAL HEALTH CARE IN NIGERIA: A CONSOCIAL NEED FOR POLICY SHIFT

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Abstract

Rural poor have lived in the shadow of overriding concern for the prosperity, development and needs of urban or state government. Much attention on the urban areas has been on the growth of capital, financial interests and social infrastructural amenities which of course has debar and ignore rural interest. The negative impact has affected the rural people. There is need to rethink the goals and process of rural development to ensure more positive outcomes for communities, people and the overall environment. The focus of this paper is on the participation of social service organization on the development of rural and remote areas in Nigeria. This paper provides a framework from which a revised model rural development is derived. These models on rural development emphasize the full participation of government in the process of rural changes.

Keywords: Rural poor, development, rural health care and rural people

Introduction

If Health programmes in the rural areas in Nigeria should ensure a deep rooted, self sustained and self retained development based. The need to have health delivery programme designed to mobilize the rural citizenry to actively participate and cooperate in the task of rural health development become imperative. This pre-supposes government that in their pursuit for a health delivery programme in the rural dwellings should have the responsibility of democratizing the rural development process by involving

the rural dwellers in planning and implementing rural health development projects and providing rural revenue credit facilities. This means that for an effective health delivery system, it must involve active rural participation, rural finance, rural credit and saving mobilization involvement and cooperation in planning, implementation of health delivery programme.

In Nigeria, an approach to health delivery scheme is still far from reality, there are several underlying factors responsible for the failure of effective and competent health management in Nigeria. These include, poor funding, non participation of communities on health care programmes, poor personnel, lack of self sustainance and rural credit facilitiies.

Having exposed thus, it is imperative to adopt an approach towards a more effective rural health services in Nigeria as a solution to solving forces acting upon rural health. For some formative evaluation basic questions are necessary to ask: How do we plan rural health policies? How do we host effective rural health programmes? What is poverty? Who are the poor? What do the poor do for living? What is peculiar about moral poverty? What is the effect of rural poverty on health? *Answer to these and similar questions are required for an effective rural poor and rural health care policy programmes.*

Who are the nigerian poor?

The paupers, beggars', disabled and informed with no visible means of sustained livelihood, the single unemployed, the homeless vulnerable families, and the social deviants who subsist precariously on the edge of the society (*Aboyade. O. 1975).*Nigerian poor is classified into three, thus:-

- **The Chronic Poor:-** This house-hold are very poor, they have humanitarian allies to income and the instrument to manage risk and even in small reductions income can have severe low sequence for thus. This people often face with mal nutrition, poor and unbalanced dietary conditions and insufficient food. This set of people also exposes to fear some diseases and may die of it.
- **The Transient Poor:-** This group lives near the poverty lines and may fall into poverty when an individual household or the economy as a whole faces hard times.
- **Special Circumstances:-** These are sub-group of population for whom general stability and properly alone will not be sufficient. Their unavailability may stem from disability, discrimination due to ethnicity, displacement due to conflict "social pathologies" of drug and alcohol abuse, donnish violence or crime. These groups may need special health programme to help them attain a sufficient standard of well being.

Conception of rural health care

The materialist conception of rural health care anchors on the fundamental assumption; health care is part and parcel of society within which individuals lives, health begins with the axiom that human beings are the basis of both the forces of production, the relation of production, social institution and practices in any society and therefore "appropriate human organismistic condition, that is healthcare can only be understood in the concrete content of the particular mode of organization of production and the dialectal relationship between the production forces and relation (*Sander Ialman 1977:8*)

Rural Health care is inseparable from the political economicc conditions under which people have met their daily needs and reproduce life *(Turshan 1977)* nor is health separated from such process as the rate of capital and profit accumulation, repression and other super structural aspects of the materialist basis of existence. Rural Health Care therefore, transcends the absence of disease. It is a state of being in which the individual has relative control through participation over his existence in a purposive and meaningful way and devoid of poverty.

Poverty or Rural Poverty could be categorize into;

(1) Culture of Poverty
(2) Poverty

Culture of Poverty

Poverty simply refers to economic deprivation and culture of poverty is a sub- culture or a way of life which develops from economic deprivation (poverty).

This sub-culture transient national boundaries. It is both an adaptation, a reaction of the poor for the marginal position in a class – stratification, high individual, capitalist society. *(Rebiwon, 1976).* It represents an effort to cope with feelings of hopelessness and despair which develops from the realization of the improbability of achieving success in terms of the values and goals of the larger society:

Maltus, in 1798 made an effort to explain the existence of poverty in rural society by attributing the phenomenon to the propensity of the poor to procreate at a rate which exceeds their means of subsistence. He posited a relationship between population growth and poverty and largely blamed the poor for their inability to control their physiological impulses.

Large number of children constitute more drain on available resources and impoverish the family by reducing the main income of the family. In adherence to African traditional hospitability and extended family system, poverty is also housed and the poor parental background finds it difficult to take care of their health care matters. Poverty by the rural poor is

that lack of basic income needed in minimum necessity of life, Poverty breed poverty. A poor individual or family has a high probability of staying poor.

Unemployment, a pointed finger to poverty is one of the major problems confronting rural Nigeria and as in many developing countries, it is to a large extent a rural phenomenon, most of these unemployed are young school leavers or drop-outs who are new entrants into the labour market with hardly any professional training or experience *(Akerele* . A. 1977).

In rural areas in Nigeria, there are poor and disenfranchised groups that have no voice and obtains little consideration from political, social or economic decisions even where they have been considered by policy decisions, the result has often been ineffectual, for whatever reasons, this group lack access to the institutions that ostensibly govern and serve its society *(Ihiesenhuman 1978:9)* and consequentlly expose to dividend of poverty which include of course poor health care management;

Any house hold afflicted by poverty is in all probability likely to have a minimum education, that confess non skill on him, the skill deficiency in turn narrows his job options to unskilled, low paid jobs, low earnings from unskilled work. This shows that such house holds would hardly afford a good medication.

Rural health care in Nigeria

Another enhancer to poverty and rural poor health care can be traced to the abysmal development of National Health development planning in Nigeria. These of course include rural health workers. They are often reported as mal-distributed in the rural areas to the disadvantage of rural poor dwellers. Rural health workers was primarily institutionalized in 1979 to improve the staffing of rural areas however, the distribution of rural health personnel has paralyses its immediate policy goal. The effect of overall manpower shortage in the labour market and poor infrastructural health care facilities is indifferent to this cause. The health care providers in the rural areas are not only a few but have been deprived of instrument of labour and means of labour. As a result rural health care is at risk; the cconsequences can easily be post predicted to the problem of inadequate health personnel distribution in the rural areas. This menace has reported repeatedly in the National health development plan in Nigeria ever since the Nigeria Independence.

As a result, there is need to provide adequate health manpower in the rural areas for effective services. Adherance to suggestion and advice; making physical infrastructures such as hospital and health centers available in rural areas would amount to adequate provision of health care facilities to the populace concerned.

Although a School of thought has buttressed that the expansion of the health workers and more infrastructural health facilities would not incessantly resolve the problem of poor rural health care services *(Fmoli 1980),* as a result, the health status of rural populations as compared with their urban counterparts has continued to bother government, as such government has embarked on programmes to finding means of providing adequate health in the rural areas.

Researchers of course in their findings discovered truly that there are shortage of trained health workers and health infrastructural facilities and there is immediate need to correct the situation perhaps by making physical infrastructures such as hospital and health centers and health providers available, it was hoped that if the health care service infrastructural facilities and health providers were made available, other health managers would be able to distribute other resources equitably within rural areas. *(Adejuyiabe 1974, Onokerrhoraye 1976).*

But little did these schools of thought know the political economy of rural settlers and dwellers. Inadequate funding and poor credit finance and poor community participation are more chronic factors that control rural health care delivery. Inadequate funding in Nigeria is reflected both in previous and present decline of budgetary allocation to the health sector on the average this has been less than 2% (1.88%) in rural area over the years (*Osenmota 1992).* This is less the minimum of 5% of total budget outlay recommended by the W. H. O (World Health Organization). Poor management of health institution is also associated with this inadequate funding and inadequate support services.

The diagnostic services available in some urban centers are non-existent in rural areas. This attitude to rural health has affected the growth and quality of health care in the rural areas. The drug in availability is a known thing, the drug revolving schemes are effectively inadequate perhaps there is need for inter – sectoral co-operation.

Poor revenue and credit finance among rural poor pose a major cause. A proportion of Nigerians rely on traditional healers for treatment due to low income per capital associated with rural areas. It is a matter of regret that up till now no major effort has been made to improve on these individual factors. Therefore, the rural people still share the same traditional traits bearing the same burden of poverty, disease, and illiteracy.

The rural people owing to low income per capital are expose to mal-nutrition, poor and unbalanced dietary conditions and insufficient food. These, include sanitary conditions and disease control. This evidently is an off shoot of low income per capital that is common place in the rural areas.

The proportion of the population of Nigeria living in extreme poverty has risen while some African countries such as Angola, Egypt and Ethiopia

have reduced their poverty rate over the last two decades; poverty attributed diseases and sickness such as child mortally, H.I.V and AIDS scourge, Tuberculosis effect have increased in six sub-sahara nation which Nigeria is included (Steve Dada 2010).

According to UN report on millennium development goal (MDG's). sub- sahara is the only region in the world requesting an increase as the HIV, AIDS and underage – five mortality rate. These have risen in Cameroon Central African Republic, Chad, Congo, Kenya and Zambia, 34 countries out of worlds 36 countries with child mortality rate, above 100 per 1,000 births are in sub-saharan Africa.

From account so far on the inadequacies in rural health care in Nigeria, obviously there is a challenge for Nigeria to strengthen her health care system across the spectrum to reduce the disparities and create a more equitable situation regarding access to health care services for the population at large. If government financial allocation to health sector is expected to achieve its course, certain policy programmes and model should be adopted in rural health care scheme in Nigeria according to classifications.

These models include:

(1) Safety Net Model,
(2) Cash Transfer Model
(3) Rural Finance / Rural Credit Model
(4) Conditional Cash Transfer Model
(5) Drug Free Waiver Exemption Model
(6) Net Work Delivery Model

Safety Net Model

This model is a poor reduction strategy, it supposes to work alongside with health insurance, health education and financial services to the rural recipients. Safety Net Programmes aid supportive rural health scheme through the provision of utilities, roads and other policies. This aim at reducing poverty among the rural populace and manage risk.

Safety Net Programmes can play four roles;

i. Safety Net model redistribute income to the poor rural people and reduce the yawning between the poor and the rich.
ii. Safety Nets enable household to make productive investments in their future that they otherwise (e.g) education, health, income generating opportunities.
iii. Safety Net helps households to manage risk at least off setting harmful bills failures that they may otherwise cope with strategies and at most providing an insurance function which would improve live hood options.

iv. Safety Net Acts allow government to make choices that support efficiency and growth.

NOTE:, The ineffectiveness of safety net model in the rural health care system lies in the details of the implementation process and stake holders' involvement therein.

Cash Transfer Model

This model directs provisions of assistance in the form of enabling cash to the poor victim, poor sick or those victims who face a probable risk of falling into rural poverty of course rural poverty concept expresses rural peasantry \, where the rural poor have neither will, nor the gleans, nor the power to do so. The main objective of cash transfer model in the rural health care is to increase the poor and vulnerable household with real incomes.

Rural Family Health Allowance Scheme

Rural family health allowance scheme is a benefit regular or occasional paid to families (Victims) of H. I. V, AIDs, Tuberculosis, Sickle Cell, etc. with children under a certain age, transfer can be in the form of drug waiver or substitution.

Conditional Cash Transfer Model

These are programmes earmark to provide cash payment to poor households, that meet certain behavioral requirement (eg) children with (HIV) care delivery system. In this model service providers have to consider target and ensure impact evaluation.

Drug Fee Waiver Exemption Model

The objective of this model is to provide people living with HIV, AIDS with financial resources to use public services such as health facilities. It will enable people to obtain free health care even when fees are charged. Exemption should be granted to victims of HIV, Tuberculosis, and other numerous diseases. These victims have special drawing rights to available drugs and health care facilities.

Net Work Delivery Model

This model directs to victims of HIV and other related diseases who could not attend clinics in the hospital as a result of psychological trauma and shame therefore there should be a healthcare delivery agencies that operate with a personnel code which is only known to the service providers and the victims. In this case the application of drugs is accomplished through a direct live- linkage between the services providers and the victims and preferably payment is made online.

Rural Financial And Rural Credit Model

This is an overall service model. It is the provision of credit, savings mobilization, insurance coverage and payment system for transfer of fund to rural sectors. In view of low income and high risk in the rural areas, effective provision of this services serve important goals of accelerated growth, poverty alleviation and reduced exposure to vulnerability. *(Akpala 2004).*

Rural settlement is characterized with diversity and such it requires a variety of diversified formal and informal institutions for the provision of innovative rural financial services to rural settlers. Once the rural settlers have bargaining powers and economic empowerment, they would eventually afford health services.

Conclusion

From the accounts, the provision of access to qualitative rural health care should be topmost on the government agenda. Government should fulfill all obligations towards making rural health care project a success. Government should adopt openness in technology and consistent leadership commitment to reduce rural poverty

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